TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-16-1007-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for the services rendered because we have submitted the appropriate paperwork needed, showing that Gallagher Bassett is indeed the correct payer for this claim."

Amount in Dispute: $756.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 22, 2015	L1832	$756.93	$680.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
3. Texas Labor Code §408.0284 sets out guidelines for defines informal or voluntary networks for DME.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 10 – (109) Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
   - BL – This bill is a reconsideration of a previously reviewed bill

- 1 – Service to be reviewed for payment by DME informal or voluntary network. Coventry DMEplus as defined in Texas Labor Code 408.0284. Contact DMEPlus at dmebilling @cvty.com

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 1 – "Services to be reviewed for payment by DME informal or voluntary network." Texas Labor Code §408.0284(b) states

   > Notwithstanding any provision of Chapter 1305, Insurance Code, or Section 504.053 of this code, durable medical equipment and home health care services may be reimbursed in accordance with the fee guidelines adopted by the commissioner or at a voluntarily negotiated contract rate in accordance with this section.

   Review of the submitted information finds that:

   - No Carrier relationship was found between the carrier and Coventry Health Care Workers on the DME and Home Health Informal Networks Report found at https://wwwapps.tdi.state.tx.us/inter/perlroot/sasweb9/cgi-bin/broker.exe?_service=wcExt&_program=progext.DME_HomeHealth_networkrpt.sas as suggest by denial remark
   - Review of the TXCOMP, Claim Network Summary finds no network listed.

   The respondent did not submit a copy of the alleged contract. The respondent did not submit documentation to support requirements of Texas Labor Code 408.0284(c), which states in pertinent part, "The carrier has a contractual arrangement between (1) the carrier or authorized agent and the informal or voluntary network that authorized the network to contract with health care providers for durable medical equipment or home health care services on the carrier's behalf; and (2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements of this section."

   The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (d) states in pertinent part,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   Review of the DMEPOS fee schedule finds the following;

   - The Medicare, 2015 Texas Fee Schedule amount found at www.dmepdac.com/dmecsapp/do/feesearch, for submitted code (L1832) is $544.12
   - Therefore, per the Division fee guidelines, $544.12 x 125% = $680.15.

3. The total maximum allowable reimbursement for the services in dispute is $680.15. The carrier previously paid $0.00. The remaining balance of $680.15 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $680.15.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $680.15 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	January 11, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.